The tables show a general decrease in mortality of 7.1 per cent. in favor of 1895. The reduction is more striking if age and the day of the disease on which the antitoxin was administered are taken into account.

In the first quinquennium of life the results are most striking, and here the mortality is reduced 13.2 per cent. in 1895, lower than it was in 1894.

The necessity of administering the antitoxin early is forcibly shown by the statistics bearing on the relation between date of administration and mortality, as it is shown that those cases in which the antitoxin was administered on the first and second days show a mortality of 4.6 per cent. and 14.8 per cent., respectively, in 1895, as against 22.5 per cent. and 14.8 per cent. in 1894.

The mortality in laryngeal cases is also shown to be greatly reduced, the percentage in 1895 being 49.3 as compared to 70.4 in 1894.

The complications of the disease were apparently not influenced by the antitoxin, as cases showing complications were rather more numerous in 1895 than in 1894. That this was not due to the antitoxin is shown by comparing an equal number of cases in 1894 and 1895 not treated by antitoxin, when it is seen that the 1895 cases show a higher percentage of complications.

The authors summarize the results of their inquiry in the following conclusions:

1. There is a great reduction in the mortality of cases brought under the antitoxin treatment on the first and second days of the disease.
2. That in this series of hospitals the combined general mortality is below that of any other year.
3. That there is a particularly remarkable lowering of mortality in the laryngeal cases.
4. That there is a uniform improvement in tracheotomy results.
5. That there is a beneficial effect produced upon the clinical course of the disease.

They consider the value of the antitoxin to be demonstrated from the study of this large number (2182) of cases; and lay particular stress upon beginning the treatment as early as possible.—*Metropolitan Asylums Board. Report of the Medical Superintendents upon the Use of Antitoxic Serum in Diphtheria.* London, 1896.

URÆMIC APHASIA.

At a recent meeting of the Hospital Medical Society of Paris **RENDU** gave the history of a patient presenting this interesting condition.

The patient was a man of fifty-six years, and was admitted to the hospital with the history of having suddenly been seized with an apoplectic attack. The morning following admission he had regained consciousness, and his three main symptoms were aphasia, monoplegia of the right arm, and a systolic murmur at the base of the heart.

From these signs a diagnosis of cerebral embolism was made. Some days later the patient was seized with a sudden attack of intense dyspnœa, with Cheyne-Stokes breathing; the urine was scant and very albuminous, and the blood contained seventy-five centigrammes of urea to the litre. The diagnosis was then made of uræmic poisoning.

The patient was bled immediately, and recovered in a day or two, both the monoplegia and the aphasia entirely disappearing.

Rendu regarded the aphasia and partial paralysis as both being due to uræmic intoxication, and in the discussion Hanot expressed the opinion that the similar lesions which may take place in pneumonia and other infectious diseases were also toxic. Duflocq mentioned a case of aphasia occurring in the course of cholera, in which the autopsy showed no lesion whatever.—*Gazette Médicale de Paris*, April 4, 1896.

THE MOBILITY OF ABDOMINAL TUMORS.

NOTHNAGEL (*Festschrift zur* 100 *jahr. Stiftungsfeier des Med.-Chir. Friedrich Wilhelms-Institutes*) in this article considers the mobility of abdominal tumors under four principal causes: Respiratory, or the motion of the diaphragm; the peristaltic motion of the stomach and intestines; external pressure; gravity.

1. All organs immediately beneath the diaphragm descend in inspiration and ascend in expiration. Diagnostic errors due to the inspiratory distention of the abdominal wall can only be avoided by experience. In the differential diagnosis of tumors of the liver and stomach the possibility of retaining the tumors in expiration is in favor of the stomach. Respiratory motions may be absent on account of pleurisy, emphysema, or adhesions, or in enormous enlargement of the liver or spleen, by which the contraction of the diaphragm is limited. The mobility of renal tumors, though slight, is important as contrasted with that of retroperitoneal neoplasms.

2. Tumors of the stomach and intestine may be moved by the peristaltic action of those organs, but the temporary disappearance of a tumor does not permit the conclusion that the growth is in the stomach or intestine. Peristaltic motion is usually limited, although sometimes it causes a considerable excursion.

3. Dislocated organs, such as the liver, spleen, and kidney, are easily moved by palpation unless adhesions have formed. Intestinal tumors are usually very movable, a fact of great importance in distinguishing between these and paratyphlitic exudates. Tumors of the stomach, especially the pylorus, have great passive mobility, but are not much influenced by respiration. Tumors of the gall-bladder, omentum, ovaries, and uterus are slightly movable, but abscess, circumscribed exudates, aneurisms, pancreatic tumors, tumors of the retroperitoneal glands, bones, and undescended testes are immovable.

4. Gravity influences especially tumors of the stomach and intestine.

HEPATIC NEURALGIA.

PARISER, in the Congress for Internal Medicine (*Centralblatt für innere Med.*, 1896, No. 17, p. 467), reported seven cases of nervous hepatic colic. This is usually mistaken for gallstone colic, and in one case of the author's an operation was performed under the erroneous idea. The clinical picture is usually precisely like that of colic from calculus. Fürbringer thinks that in hepatic neuralgia the most intense pain is localized in the liver, and is not radiating, and although this is true in many cases, exceptions occur. The attacks last from a few minutes to four or more hours. As in biliary colic, the attack may end in vomiting. The disease is a visceral neurosis, with a neurasthenic or hysterical basis. The most successful treatment consisted in the use of tonics, the exclusion of exciting causes, and cannabis indica.